

Case Number:	CM15-0081569		
Date Assigned:	05/04/2015	Date of Injury:	12/29/2002
Decision Date:	06/09/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/28/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania
 Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 37 year old female who sustained an industrial injury on 12/29/2002. Diagnoses have included left cervical radiculopathy, myofascial pain syndrome, occipital neuralgia, left sacroiliac joint dysfunction, failed back surgery syndrome and lumbar radiculopathy. Treatment to date has included nerve blocks/injections, epidural steroid injection, spinal cord stimulator, chiropractic treatment, physical therapy, home exercise program, transcutaneous electrical nerve stimulation (TENS) and medication. Reports from March 2014 to March 2015 reflect ongoing pain; it was noted that pain medication reduces pain and allows the injured worker to complete her activities of daily living and stay active. Submitted visits were approximately monthly from June 2014 to March 2015. Work status was noted as permanent and stationary; return to work was not documented. Dilaudid, fentanyl, and zanaflex have been prescribed since March 2014. Urine drug screens in June and September 2014 were positive for multiple benzodiazepines, which were not listed as prescribed medications; these findings were not addressed. In addition, the progress note of June 2014 states that urine drug screen was noted to be positive for Norco; the treating physician documented that the injured worker reported leftovers from a previous prescription and that she was advised to dispose of them. Progress note of October 2014 documents that there was no aberrant behavior and no side effects of medications. According to the progress report dated 3/27/2015, the injured worker complained of lower back pain. She also complained of pain in the right leg. Her current pain rating was 5/10 on a good day and 10/10 on a bad day. Cervical exam revealed severe tenderness and trigger points over the paracervical area and limited range of motion. Hawkin's and Neer's

test were positive. Exam of the lumbar/sacral area revealed severe tenderness over the right lower lumbar facet joint, spasm and limited range of motion. Gait was slow and antalgic. An signed opioid contract was noted. Authorization was requested for Zanaflex, Fentanyl, Dilaudid and a urine toxicology screen. On 4/6/15, Utilization Review (UR) non-certified requests for the items currently under Independent Medical Review, citing the MTUS, ACOEM, and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Zanaflex 4 mg Qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex) Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

Decision rationale: This injured worker has chronic low back pain. Zanaflex has been prescribed for one year. There was no documentation of functional improvement as a result of use of zanaflex. Work status was noted as permanent and stationary, and there was no documentation of return to work, improvement in specific activities of daily living, decrease in medication use, or decrease in frequency of office visits. The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long-term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Tizanidine (Zanaflex) is FDA approved for management of spasticity and unlabeled for use for low back pain. Side effects include somnolence, dizziness, dry mouth, hypotension, weakness, and hepatotoxicity. Liver function tests should be monitored. It should be used with caution in renal impairment and avoided in hepatic impairment. There was no documentation of monitoring of liver function tests. Due to length of use not in accordance with the guidelines, lack of functional improvement, and potential for toxicity, the request for zanaflex is not medically necessary.

Fentanyl 50 mcg/ hr patches Qty 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy Page(s): 74-95, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: This injured worker has chronic back pain. Dilaudid and fentanyl have been prescribed for one year. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with

specific functional goals, return to work, random drug testing, and opioid contract. The submitted progress notes describe the same goals but do not document achievement of any specific goals. Work status was noted as permanent and stationary, and there was no documentation of return to work, improvement in specific activities of daily living, decrease in medication use, or decrease in frequency of office visits. An opioid contract was discussed. Urine drug screens were collected on the dates of office visits, not at random as advised by the guidelines. In addition, results of two urine drug screens were positive for benzodiazepines, which were not noted as prescribed, and these findings were not addressed. The records clearly indicate inconsistent urine drug tests and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. One of the urine drug screens was also positive for Norco, which was not prescribed, and the treating physician documented this was due to use of a previous prescription. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in specific activities of daily living were not noted. One progress note states that there was no aberrant behavior, which is not substantiated by the urine drug screens. The documentation does note that there were no side effects of medications. As currently prescribed, and in consideration of the lack of functional improvement and inconsistent urine drug screens, fentanyl does not meet the criteria for long-term opioids as elaborated in the MTUS and is therefore not medically necessary.

Dilaudid 4 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy Page(s): 74-95, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: This injured worker has chronic back pain. Dilaudid and fentanyl have been prescribed for one year. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. The submitted progress notes describe the same goals but do not document achievement of any specific goals. Work status was noted as permanent and stationary, and there was no documentation of return to work, improvement in specific activities of daily living, decrease in medication use, or decrease in frequency of office visits. An opioid contract was discussed. Urine drug screens were collected on the dates of office visits, not at random as advised by the guidelines. In addition, results of two urine drug screens were positive for benzodiazepines, which were not noted as prescribed, and these findings were not addressed. The records clearly indicate inconsistent urine drug tests and the inconsistent results are not explained by treating

provider, which would be necessary for continued usage. One of the urine drug screens was also positive for Norco, which was not prescribed, and the treating physician documented this was due to use of a previous prescription. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in specific activities of daily living were not noted. One progress note states that there was no aberrant behavior, which is not substantiated by the urine drug screens. The documentation does note that there were no side effects of medications. As currently prescribed, and in consideration of the lack of functional improvement and inconsistent urine drug screens, Dilaudid does not meet the criteria for long-term opioids as elaborated in the MTUS and is therefore not medically necessary.

Urine toxicology screen (UDS) G0431: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (chronic) - Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing p. 43, opioids p. 77- 78, p. 89, p. 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

Decision rationale: Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. There was no documentation of risk stratification for aberrant behavior, which would be necessary to determine the frequency of urine drug testing. One progress note states that there was no aberrant behavior, which is not consistent with the findings on prior urine drug testing. Specific risk stratification was not documented. The MTUS recommends random drug testing, not at office visits as has occurred in

this case. The treating physician has not provided an adequate response to the prior failed drug tests. Prescribing after the failed tests did not change and there was no change in the treatment plan in response to the failed tests. Drug tests, which are performed without a meaningful response from the treating physician, are not indicated. Although there is a valid indication for drug testing for some patients, in this case the testing to date has not been performed or interpreted in a manner consistent with guidelines. Any additional testing is therefore not medically necessary. In addition, the associated opioids have been determined to be not medically necessary. For these reasons, the request for urine toxicology screen is not medically necessary.